The Prevention Connection
NEWSLETTER

Marijuana and Montana Youth

by Kevin Stewart, M.Ed., LAC

—Marijuana is still the number two drug of choice for Montana's youth. Alcohol is number one.

Methamphetamine gets a lot of media attention these days. Understandably so. It is an extremely dangerous drug associated with a rapid decline at all levels of functioning. At the same time, we who are working in the prevention, intervention and treatment arenas encounter many more youth struggling with cannabis problems than problems with other illicit drugs. The 2004 Montana Prevention Needs Assessment data indicates that about 54 percent of high school seniors statewide have used marijuana, whereas only about 9.5 percent have tried stimulants (including methamphetamine, cocaine and diverted prescription medications).

In an informal survey of the youth admitted to our treatment program here at Turning Point (both intensive outpatient and standard outpatient), approximately 80 percent identified cannabis as their primary drug of choice. They use alcohol and other drugs as available, but identify cannabis as their staple. There is nothing "casual" about their use: the majority indicate that they use substantial amounts on a daily basis when available. Frighteningly, the average age for first use of cannabis among adolescents is decreasing.

Clear evidence suggests that marijuana is not a safe drug by any measure. Some of the documented negative effects are related to acute cannabis intoxication. Some relate to long- term and regular cannabis use, and can persist for months or even years. We know that cannabis can cause damage to lung tissue and the cardiovascular system. Regular use has a profound effect on memory, learning, motivation and cognitive functioning in general. There is also evidence that marijuana use can increase the risk of onset of psychosis in youth predisposed to that condition. There are some indications in the research that cannabis use by adolescents can cause arrested brain development that may be irreversible. Hospital emergency room visits associated with marijuana use by 12-17 year-old youth include acute paranoia and accidents and account for more than twice the number of visits associated with cocaine and heroin combined. Ergo, this is not a "safe drug." Even proponents for the legalization of marijuana for recreational use, such as the National Organization for the Reform of Marijuana Laws (NORML), recommend that cannabis use not start before adulthood and yet the vast majority of cannabis users start in adolescence.

Cannabis intoxication adversely affects judgment, coordination and reaction time. The ability to operate a motor vehicle is significantly impaired. Under Montana law, any person (including adolescents) may be cited for a DUI if found to be under the influence of cannabis while operating a vehicle. And yet, while many youth report that they would never drive under the influence of alcohol, they believe it is fine to drive while "stoned" on cannabis. This places them—and everyone else on the road—at increased risk for accidents.

Cannabis is highly addictive both psychologically and physiologically. The

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Marijuana and Other Illegal Drugs

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The Vicki Column

—Acculturation: The process by which the culture of a particular society is instilled in a human from infancy onward. *n. – www.dictionary.com*

When I was a teenager, many parents were relatively easy to shock, probably because they drew the line in the sand close to their own feet. Lots of us had to wait until we were 16 to get our ears pierced (*once!).* Some parents even held to the notion that only tramps and gypsies pierced their ears. Of course, this made all those hoops and studs all the more inviting. That's normal. Developmentally, teens are distancing from their parents and renegotiating the power structure within the family. One way is to take risks, act out . . . to shock their parents.

Today this individual development is occurring in a culture where marijuana has been trivialized and normalized for the past forty years. There's no question that this drug has been acculturated. Unless they've lived out of reach of popular music, television, movies and the news, our children have been bombarded with misinformation since infancy. Unfortunately, many of today's parents treat smoking marijuana almost like a rite of passage. The upshot is that marijuana is the most widely used illicit drug in our nation. Kids are using—and getting addicted—at younger ages than ever before.

Google "*marijuana and music"* and in the first twenty entries (of 1,430,000), only one includes a (short) anti-marijuana message. Marijuana merchandise abounds. The highly recognizable leaf is on posters, CDs, hats and t-shirts . . . there are magazines and websites devoted to it, and paraphernalia is openly sold all over the country. The legalization of medical marijuana compounds an already mixed message.

But, hey, that isn't a problem, right? After all, marijuana it isn't as destructive as meth or cocaine, heroin or ecstasy.

Think again. Marijuana addiction is the most commonly treated addiction among Montana's youth, the second most common among adults. Marijuana isn't groovy and it isn't benign. It's scary, addictive and dangerous. It's frequently adulterated with even more sinister substances. It alters the brain, damages the lungs, affects learning and achievement and can lead to mental health problems. And as long as we acknowledge this dangerous drug as "okay," tacitly or explicitly, how far will our kids have to go to shock us?

Vicki

Notes From the Edge

A Laundry List of Failures

by Maria Nyberg, MSW, God's Love Family Transitional Housing Program

A homeless methamphetamine-addicted mother fights an uphill battle with herself and the system in an attempt to achieve stability. *Kathy**, a 30-year old single mom with a 5-year old son, *Mike**, entered the *God's Love Family Transitional Housing Program* on October 25, 2004. She had been evicted from her HUD apartment in Townsend after multiple infractions. Her son had already experienced placement in the Washington foster care system.

Kathy identified multiple obstacles to overcome in order to achieve stability and permanency, including lack of: parenting skills, education, budgeting skills and employment. Compounding these issues was a need for counseling to address multiple traumas and drug issues.

As Kathy and I developed her case plan, she was very agreeable to services. Kathy stated that she had not used methamphetamines for the past two years. Consequently AA/NA was the only recommendation for her addictive issues. As I soon learned, though, while Kathy was verbally cooperative, her follow-through was dismal. Every week she faced a laundry list of failures from missing appointments, non-completion of tasks, sleeping and not supervising her son to poor hygiene. Her

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*Names have been changed.

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addictive process progresses quickly in youth, and those who are addicted to cannabis are highly resistant to treatment intervention. Their prognosis is highly guarded at best.

Cannabis addiction is very serious, and successfully treating cannabis addiction once it has fully developed is difficult. According to Stephen Bogan with the Washington State Division of Alcohol and Substance Abuse and noted authority on cannabis use, juvenile cannabis addicts who have experienced a treatment episode and attempt abstinence have a relapse rate significantly higher than addicts attempting recovery from other drugs. In fact, many of the youth in our treatment program who are also in structured legal programs that require regular urinalysis will abstain from cannabis use for a while or temporarily switch to another substance (such as alcohol) that is harder to detect than THC. These youth will repeatedly claim that as soon as they are no longer under intense scrutiny that they will return to regular cannabis use.

Many youth who enter treatment are convinced that marijuana is not addictive and that everything would be just fine if it were just legalized. We must address this issue aggressively with prevention and early intervention strategies.

In spite of evidence to the contrary, our society clings to the common view that marijuana is a relatively benign drug. The passage of the Medical Marijuana Initiative is a reflection of this attitude in our culture as a whole. Clearly, the issue as it relates to youth is distinctly different from providing terminally ill adults access to the drug. However, two major concerns with this new law will impact youth and their perspective toward marijuana use. The first is that this highly addictive and dangerous drug will be increasingly viewed as "medicine" by youth. The second concern is that on the heels of the availability of "prescription" marijuana will come an increase in the general availability of marijuana in our communities. This is a huge concern because prevention research clearly shows that availability is one of the key factors contributing to the likelihood that youth will use any given substance. Marijuana is no exception.

If we see an increase in availability, even through legal channels, we will also see an increase in the availability of marijuana to youth. Prevalence is already on the rise. Recent information from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that treatment admissions for adolescents with cannabis addiction have increased at a rate roughly three times the rate of admissions for any other drug. Prevention, early intervention and treatment professionals must be equipped with accurate information to confront the common misconceptions of youth.

There is hope. One approach that shows great promise is the *Cannabis Youth Treatment Program* series available from the Center for Substance Abuse Treatment. It consists of a series of treatment protocols designed to address cannabis use among teens. At Turning Point, we have adapted one of these protocols to fit *Outlook*, our early intervention program for youth cited for possession of marijuana or paraphernalia. This protocol consists of a combination of motivational enhancement and cognitive behavioral strategies that address core issues related to the young marijuana user. Outlook provides a specialized approach to cannabis users analogous to intervention programs designed for youth who have obtained a Minor In Possession charge for alcohol.

It is interesting that Montana has specific mandates and a state approved curriculum for youth cited for possession of alcohol, but nothing similar in place for youth cited for possession of marijuana or paraphernalia. Typically, local youth courts have jurisdiction over such cases, and considerable latitude regarding the consequences imposed. In Missoula, Turning Point works closely with the Missoula County Youth Court on cannabis possession cases. Together, we have developed a referral system that allows officers with the Youth Court to easily refer offenders to Outlook.

Marijuana can have adverse effects on physical safety and health, emotional stability, academic performance, legal status and future potential. We must be aggressive in our approach to prevent and/or treat cannabis use among our adolescents. The evidence is clear. We cannot be equivocal in our stance.

—Kevin Stewart, M.Ed.,LAC, is the Director of Adolescent Programs for Western Montana Addiction Services (Turning Point) in Missoula.

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Notes From the Edge

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living quarters were in disastrous disarray. Her therapist, her case worker from the Career Training Institute, and myself were all aware that additional problems existed that were contributing to her lack of progress. With great effort, we were able to make a referral for a neuro-psych evaluation. Her appointment for the evaluation was seven weeks from the date of referral.

On January 24, 2005, Kathy was evaluated at Boyd Andrew Drug and Alcohol Treatment.

She was given a guarded recommendation for intensive out-patient treatment. The evaluation indicated that she was close to meeting the criteria for in-patient treatment. Just one week after starting outpatient treatment, Kathy had her first documented relapse. Her chemical dependency counselor recommended in-patient treatment. At that time, Kathy was facing a projected admittance date of May 7, 2005.

Kathy had to wait nearly three months before she was able to receive the recommended treatment. Boyd Andrew Treatment Center offered continued intensive outpatient treatment until she was able to go into in-patient treatment, but Kathy and her community support team struggled to help her remain in her current programs. She was unable to follow through with appointments or to manage many aspects of her life. The chaos in her life continued to mount in spite of her gargantuan efforts and those made on her behalf.

On March 6, 2005, as the result of her methamphetamine use, Kathy called the Child Abuse Hotline. She felt out of control and unable to care for her son. The Department of Family Services placed Mike in emergency foster-care—Mike's second experience in foster-care as a result of his mother's use of methamphetamines. On March 7, 2005, Kathy was asked to leave the transitional housing program at God's Love until she had completed the in-patient drug and alcohol treatment program. Her addictive behaviors had become too disruptive for the housing program. Kathy has remained in contact with me several times a week, problem-solving issues related to her son's placement in foster care, her homelessness and how to keep her pre-existing appointments.

MCDC is the state's only publicly funded in-patient treatment program, and MCDC staff attempted to admit Kathy into their treatment program earlier than the projected date. They asked her to call Boyd Andrew every Wednesday to see if they'd had a cancellation and would be able to admit her earlier. Kathy, with help from the God's Love Family Transitional Program, was able to maintain weekly contact. Her follow-through had positive results: she was admitted for in-patient treatment to MCDC on April 6, 2005.

Kathy's circumstances are not unusual. In 2004, God's Love Family Transitional Housing program served 26 adults suffering from drug/alcohol addiction. Boyd Andrew Drug and Alcohol Treatment Center and Leo Pocha Addiction Counseling Center provide community-based treatment whenever possible. The AA/NA community provides outstanding service/support before and after treatment, but sometimes in-patient treatment is required.

The criteria for in-patient treatment are very strict. Individuals whose addictive behaviors require in-patient treatment find themselves with a clear dilemma. They are unable to control their addictive behaviors with the benefit of community services alone, and yet their admission dates might be 6+ weeks away. In the meantime, the serious consequences of their addictive behaviors continue to mount. Many are already dealing with the court system, Department of Corrections or the Department of Family Services. Kathy—and many others like her—also face homelessness.

These problems create great challenges. In these times of scarce resources and increasing problems with addiction, what are the answers? God's Love Family Transitional Housing Program plans to meet with Boyd Andrew Drug and Alcohol Treatment and Leo Pocha Addiction Clinic to collaborate and develop effective methods for working with individuals who are awaiting in-patient drug and alcohol treatment. We will also take every opportunity to educate community and state leaders as to the needs and challenges faced by individuals/families with addictions and the agencies that serve them. Ultimately we must recognize that for Kathy and many others like her, waiting for treatment is simply not a viable option.

—Maria Nyberg is a licensed social worker. She manages the God's Love Family Transitional Housing program in Helena.

Arrests and Seizures

— Montana authorities reported 222 arrests for drug abuse violations to the Federal Bureau of Investigation in 1998, and 229 in 1999. In 2000, the number jumped to 398, then jumped again to 442 in 2001. in 2002, there were 725 drug arrests reported in Montana.

— The majority of cocaine available in Montana comes from Mexican poly-drug trafficking groups with sources of supply located in Washington and the other southwestern border states.

— The majority of methamphetamine in Montana is trafficked by Mexican national groups, with numerous small-scale local laboratories appearing.

— Ecstasy is distributed in Montana by local independent dealers who transport quantities of 1,000 or more tablets from Denver to Montana.

— The majority of the marijuana consumed in Montana originates from Mexico, where poly-drug organizations transport marijuana in vehicles from the southwestern border states. Locally produced marijuana is grown indoors; "B.C. Bud" is often smuggled directly into Montana across the Canadian border.

Source: Office of National Drug Control Policy: State of Montana. Profile of Drug Indicators. 2004. www.whitehousedrugpolicy.gov/statelocal/mt

Little Adults? *Think Again*

by Dr. Richard Wise

Teens are *not* little adults. Teenage brains are in the formative years. Many of the tasks teens must accomplish to move to the next developmental level include learning, initiative and social skills. The teen's ultimate goal is independence. Essential to this independence is motivation. Marijuana is bad for teens because it almost always causes loss of motivation. When teens smoke pot, they get high, they want to get high again…and often start missing school. *Miss a test? Miss some homework and another test? Oh well. Might as well get high.* And right then and there we hit the dead end street for motivation. If kids go to school high, they might think they're getting something out of it, but what they thought they were learning while they were high is gone the next day. That's because the short-term effects of marijuana use include memory loss, distorted perception, trouble with thinking and difficulty with problem solving.

Use of marijuana has many adverse health, safety, social, academic, economic and behavioral consequences. Teenage boys are often disturbed to hear that marijuana affects the part of the brain that controls sex and growth hormones. It can decrease testosterone levels, and will occasionally enlarge the breasts. Regular use can decrease sperm count and increase the numbers of abnormal and immature sperm. Teenage girls who frequently smoke marijuana also face risks tied to their gender. They often have irregular menstrual cycles coupled with depressed female hormone levels and raised testosterone levels. Even though these effects may be reversible, it can take months to restore regular menstrual cycles. Marijuana has also been shown to adversely affect the immune system, probably decreasing resistance to infections. Particularly for young people, marijuana use can lead to increased anxiety, panic attacks, depression and other mental health problems. Many kids wind up in the emergency room when reality becomes too distorted.

The average levels of THC, the active drug in marijuana, have risen from one percent in the mid 1970s to more than 6 percent in 2002. Sinsemilla (a highly potent form of marijuana obtained from unpollinated female plants) has increased in the past two decades from six percent to more than 13 percent, with some samples containing THC levels of up to 33 percent. At current levels, THC can actually cause psychotic breaks from reality among those who are susceptible.*

Contrary to one of the most prevalent myths of our times, marijuana *is* an addictive drug. The 2003 National Survey on Drug Use and Health identified 4,198,000 Americans who meet criteria for *marijuana dependence* or *marijuana abuse*. This figure exceeds the numbers for abuse and dependence of cocaine, pain pills and heroin combined.

Addiction equates to compulsion, loss of control, and continued use despite adverse consequences. The bottom line is that use often comes to affect the individual in every facet of his/her life: financial, spiritual, legal, spiritual, physical and social. Coupled with the developing brain of the adolescent, this can mean devastating effects on the future.

—Richard Wise, M.D., is affiliated with Pathways Treatment Center, a co-occurring capable facility that offers an integrated program of emergency, in-patient and day patient services to adults and adolescents. Pathways provides evaluation for adults and adolescents with alcohol or substance abuse problems and devises individualized treatment strategies. Their treatment team includes a board-certified senior medical director, a chemical dependency medical director certified in addiction medicine, psychiatrists, psychiatric social workers, licensed professional counselors, licensed addiction counselors and professional nursing staff. Pathways is a division of Kalispell Regional Medical Center. For more information, visit www.krmc.org/ or call 406-752-5111.

**Source cited: www.whitehousedrug policy.gov/ publications/marijuana_ myths_facts/ intro.pdf)*

Definition of Addication

Seven accepted criteria are used to define chemical dependence or addiction. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), a diagnosis of addiction corresponds with having at least three of the following seven criteria pare present in the same 12-month period:

1. *Tolerance: Using more of a substance over time to get the desired effect of the substance using the same amount.*
2. *Withdrawal.*
3. *The substance is used in larger amounts or over a longer period of time than intended.*
4. *Inability to cut down despite efforts to do so.*
5. *Large amounts of time attempting to acquire, use or recover from the substance.*
6. *Important social, occupational or recreational activities are given up or reduced because of substance use.*
7. *Continued use despite recognized harm.*

Flirting with Disaster:
Teen Marijuana Use

by Pat Murphy

I recently reviewed the 2004 Prevention Needs Assessment figures. I was distressed to note that in two years time, Ravalli County children report using marijuana at an increasingly younger age—9.9 percent of respondents had used marijuana before age 13, up from 8.2 percent in 2002. Also, teens' beliefs that there is little or nothing wrong with smoking marijuana has increased from 25.4 percent to 27.5 percent. Unfortunately, this perception couldn't be farther from the truth.

Marijuana use can have serious consequences for teens who choose to use. The American Psychiatric Association warns that marijuana can trigger panic attacks and psychoses in those users who experience anxiety or depression. In addition to being a risk factor for the use of other drugs, marijuana use decreases mental functioning. The U.S. Department of Health and Human Services reported on a 2002 study that heavy marijuana use (5 or more joints a week) can actually lower I.Q. This study compared the scores of young adults (ages 17-20) with scores taken when they were between the ages of 9-12, and before they started smoking pot. For those who continued to smoke five ore more joints a week, I.Q. scores dropped on the average of 4.1 points.

Marijuana use can also damage a young person's future. Nine professional organizations including the American Academy of Family Physicians list four critical areas of concern.

1. Early age of initiation of pot makes young, developing brains more vulnerable to neuropsychological deficits, especially those affecting verbal abilities.
2. Heavy marijuana use impairs teens' ability to concentrate and retain information, especially during peak learning years.
3. Teens with grades of "D" or below have been shown to be four times more likely to have used pot in the last year than those students with "A" grades.
4. Students who drink or use drugs are five times more likely to drop out of school.

Compounding the problem is the fact that many parents underestimate their children's drug usage and may remain ambivalent to practicing prevention strategies at home. A national survey done by the Partnership for a Drug-Free America showed that 18 percent of parents thought that their children had tried marijuana—40 percent of teens said they had tried it.

Parents hold the key to keeping their children drug free. *Keeping Youth Drug Free* (2002) cites research showing that parental influence is the major reason youth *don't* use drugs. For example, 30.2 percent of adolescents whose parents didn't strongly disapprove reported using marijuana in the last 30 days in comparison with 5.5 percent of those whose parents disapproved.

Parents must be convinced that they are the most effective prevention strategy available for their teens. *Keeping Youth Drug Free* offers parents six strategies.

1) Establish and maintain good communication with your teen. A recent survey showed only 26 percent of teens felt they communicated positively with their parents (Search Institute, 2002). Be sure to set aside a few minutes a day to talk to your child. Ask questions and practice active listening. Make sure s/he feels comfortable talking about sensitive topics and provide nonjudgmental facts about drug use.
2) Get involved in your child's life. If nothing else, have dinner together. The National Center on Addiction and Substance Abuse reported that families who eat together at least five times a week decreased the incidence of marijuana use by 16 percent.
3) Make clear rules and enforce them consistently and with appropriate consequences. Some teens use drugs to take risk and rebel. By developing clear rules about the use of illegal drugs, you are helping your child view drugs as an unacceptable risk.
4) Be a positive role model. Don't use illegal drugs yourself and don't involve your child in your use of alcohol, tobacco or illegal drugs by asking them to *get you a beer*.
5) Teach your child to involve themselves with positive friendships and to feel comfortable refusing offers of drugs and alcohol.
6) Monitor your child's activity. Mulhall, et al.(1996) found that children with the least monitoring (i.e., latchkey kids) initiated drug use at earlier ages.

Good parenting is the first defense against teen drug use. Please pass it on.

—Pat Murphy is a Project Specialist with Kids First of Ravalli County, a prevention organization in Hamilton, Montana. She can be reached at (406) 375-9588 or by email at murphyp@bitterrootkids.org.

Sources:

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Driving Under the Influence

by Jenna Caplette

—Marijuana *does* impair driving ability.

In 2000, the National Highway Traffic Safety Administration (NHTSA) found that "marijuana and alcohol severely impact driving performance." Because of the complications of field testing for drug impairment, you won't find many citations for driving under the influence of drugs in county police reports—but safety isn't simply about who is arrested for what. Safety is about saving lives—yours, a loved one's, a neighbor's.

What about drunk *and* drugged? Anne Riemer, adolescent counselor at Alcohol and Drug Services in Gallatin County, emphasizes that "DUI means driving under the influence of *anything*" that impairs driving ability, including prescription medications. Mix these and any illegal drug with alcohol, and impairment levels can dramatically increase. Add impairment to Montana's unpredictable weather and slow reaction times become even more dangerous. Throw in impairment to teen drivers just learning to drive and the combination quickly becomes deadly.

Riemer says that when she taught court-mandated DUI classes, some offenders believed that "alcohol speeds them up for driving and marijuana slows them down, so the two drugs balance each other out." In her work with adolescents, she often hears, *I'm driving so I'll just smoke pot, not drink and drive. I still want to party, to have fun. I'm not drinking and driving—of course not.* "They're completely in denial about the risks of driving stoned."

Alison Counts, Student Assistance Program Coordinator for Belgrade Schools, explains, " The way marijuana changes the brain affects a person's perception. It allows them to believe they are in control when driving a car when they really are not. Marijuana changes perception of time and space. They may have tunnel vision, may sense themselves floating above their vehicle, but still believe they are in control. THC slows cognitive ability, ability to focus, and reaction time."

Parents and other adults often have mixed feelings about marijuana use because of their own adolescent experiences with it. They pass that attitude on to youth. The thing is, in the 1960s, marijuana's average THC content was less than 1 percent. THC is the chemical in marijuana that affects the brain. Today marijuana's THC content averages 14 percent and may be as high as 30 percent. Riemer says, "THC affects your perception of time and space. Cumulatively, it coats brain cells, slowing down the ability of the brain to communicate with itself. People think this is a benign drug, but it effects the body a long time because it stays in the body."

In their resource on marijuana compiled for parents, the National Institute on Drug Abuse, sums up: "Marijuana affects many skills required for safe driving: alertness, the ability to concentrate, coordination, and reaction time. These effects can last up to 24 hours after smoking marijuana. Marijuana use can make it difficult to judge distances and react to signals and sounds on the road."

Basically, "When users combine marijuana with alcohol, as they often do, the hazards of driving can be more severe than with either drug alone."

It's impossible to detach enough from your own experience of driving under the influence of any drug to have a clear idea of the level of risk you bring to yourself and others. Counts says, "Because perception is changed, it is difficult to convince the user they are not a safe driver when they are under the influence. They truly believe they are a better driver." She pauses. "Not so."

—Jenna Caplette is a prevention writer for Gallatin Safe Kids, Safe Communities and works with the Gallatin County DUI Task Force. She can be reached at 406-585-1492 or visit www.gallatinduitask force.us.

Learn more about marijuana: *www.marijuana-info.org/*

Top 10 Marijuana Myths

1. *Marijuana is harmless*
2. *Marijuana is not addictive*
3. *Marijuana is not as harmful to your health as tobacco.*
4. *Marijuana makes you mellow.*
5. *Marijuana is used to treat cancer and other diseases.*
6. *Marijuana is not as popular as MDMA (Ecstasy) or other drugs among teens today.*
7. *If I buy marijuana, I'm not hurting anyone else.*
8. *My kids won't be exposed to marijuana.*
9. *There's not much parents can do to stop their kids from experimenting with marijuana.*
10. *The government sends otherwise innocent people to prison for casual marijuana use.*

http://www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts/

Got Milk?

by Sherrie Downing, Editor

Mary Jane has always been around, but somewhere along the line, she's acquired a myriad of new aliases: Lucas, Marley, Mary & Johnny, Meg, Mary Weaver, Burnie, Herb, Greta, Monte, Pat, Siddy, TJ and many, many others. There's probably always been a language designed to shut out adults and the uninitiated, but when I started researching marijuana for this issue, I was astonished to find that a whole language embraces this drug. What once was pot, weed, reefer or hemp now has hundreds of names—names you probably wouldn't think twice about hearing your kid say, including many that sound like lunch. Along with the old Alice B. Toklas brownie, lots of other food names have been attached to marijuana: Burrito, Broccoli, Loaf, O.J., Lima, Green Giant . . . Salt & Pepper.

Dozens of the names I found were common words that seem innocent enough and certainly don't have an obvious connection to marijuana. Who would think Ashes, Airplane, Bale, Bar, Block, Pin, Ditch, Rope, Scissors, Prescription or Skunk would stand for marijuana—much less Bash, Poke, Shake or Blonde? And then there were the horticultural terms—Queen Ann's Lace, Fir, Flower, Root, Pod, Seeds, Red Dirt. There are all kinds of weeds, Railroad, Drag, Draf, Crazy, Crying, Giggle, Loco and Laughing weeds. I found practically every color you could think of, too, usually coupled with a place: Mexican, Cambodian or Panama Red, Chicago Green, Acapulco Gold, Pakistani, African or Chicago Black, Manhattan Silver and Kentucky Blue. Some names hark back to times long before the current generation was even thought of: Assassin of Youth, Killer Weed, Yellow Submarine and Rainy Day Woman were all spawned by old music or movies. And some of the hundreds of names sound like baby talk: Bobo, Bammy, Cheeba, Boo, Dinkie Dow, Chillums.

In all, I found around 300 names for "plain old" marijuana at *parentingteens.about.com.* There were affectionate names, playful names, descriptive names . . . and names without any apparent rhyme or reason. In and of itself, this is disturbing because it denotes the common place, wide-scale acceptance, an integration with the very fabric of our culture. But there was something even darker and more frightening lurking in this lengthy list of slang terms. Dozens of terms turned up for marijuana adulterated with other substances: heroin, cocaine, PCP, crack, meth, insecticides, opium, codeine cough syrup, ketamine, MDMA, psilocybin and formaldehyde—or combinations of these and others. There was a significant number of names for marijuana cigarettes that had been dipped in embalming fluid (formaldehyde and alcohol), then laced with PCP—Fry, Wack, Wet-wet, Amp, Water-Water, Wetdaddy, Drank, Lily, Wet, Ill, Crazy Eddy, Purple Rain, Clickem, Love Boat . . . and Milk.

Many of these combinations are deadly. The effects can be irrevocable. Some "common" additives, including PCP, methamphetamine, heroin, cocaine and opium, are highly addictive. Many—alone and in combination—can precipitate hallucinations, delusions, violence and a host of dangerous physical conditions, including brain damage, convulsions and death. Marijuana in and of itself is not benign, but after doing this research, I couldn't help wondering how many of them had been exposed to far more than they ever bargained for. How many got *Milk*? It's chilling.

Talking to Your Kids

Parents can use some of their good conversation time with children and adolescents to make it clear that they don't want them to use marijuana (or other drugs). You should state clearly to your pre-teens and teens that you would be very disappointed if they started using marijuana. You may also want to explain that marijuana use impedes concentration, memory and motor skills, and that it interferes with motivation, leads to poorer school performance, and can cause users to disappoint the people most important to them. All of this can be communicated in a loving way . . . "I love you and I want the best for you, so I hope you won't try marijuana." www.theantidrug.com

PNA Data Bite

The 2004 Prevention Needs Assessment data revealed that approximately 54 percent of Montana's 12th graders had tried marijuana at some point in their lives; 26 percent had used it within the past 30 days.

Crazy Eddie and Purple Rain

Marijuana Dipped in Embalming Fluid and Laced with PCP

According to the Office of National Drug Control Policy, it is common for marijuana to be laced with phencyclidine (PCP) or embalming fluid, both of which produce hallucinogenic effects (psychedelic apparitions or feelings of euphoria or rage). Marijuana joints are dipped in embalming fluid to slow the burn rate and laced with PCP to enhance the effects. The percentage of formaldehyde found in embalming fluid ranges anywhere from 5 to 29 percent. The percentage of ethyl alcohol, the psychoactive ingredient found in alcoholic beverages, varies anywhere from 9 to 56 percent.

Embalming fluid can be purchased directly from chemical companies, after which PCP is added before distribution on the street. Street drug dealers sell individual joints soaked with embalming fluid for $10–20. They reportedly taste like rubbing alcohol and smell like gasoline, but they burn more slowly than untreated marijuana joints and offer the chance of a prolonged high. Although this treatment of marijuana is thought of as an emerging drug trend, it has been around since the 1970s.

Short-term Effects:

— Anger and frustration
— Depression
— Hallucinations and delusions
— Headache
— Impaired vision and coordination
— Increase in women's sexual appetites
— Loss of consciousness
— Memory loss
— Paranoia
— Physical violence
— Sleepiness
— Vomiting

Long-term Effects:

— Brain damage
— Bronchitis
— Coma
— Convulsions
— Coughing
— Destruction of muscle tissue
— Fever
— Heart attack
— High blood pressure
— Inflammation of the throat, nose, and esophagus
— Kidney damage
— Lung damage
— Maturation process cessation
— Pneumonia
— Spinal cord destruction

http://www.drugfreeaz.com/news/articles_marijuana.html

Polydrug Abuse

Among the 1.9 million admissions reported to SAMHSA's 2002 Treatment Episode Data Set (TEDS), more (56%) reported the abuse of multiple substances (polydrug use) than abuse of any single substance.

— Among polydrug admissions, alcohol was the most common substance reported (76%), marijuana was second (55%), followed by cocaine (48%), opiates (27%) and other drugs (26%).
— Younger admissions were more likely to report polydrug abuse than older admissions: 65% of those younger than age 20 reported polydrug abuse compared with 41% of those aged 45 or older.
— More teens enter treatment each year with a primary diagnosis of marijuana dependence than for all other illicit drugs combined. Currently, 62 percent of teens in drug treatment are dependent on marijuana.
— The proportion of admissions for primary marijuana abuse increased from 6 percent in 1992 to 15 percent of admissions to treatment in 2000.35 Almost half (47 percent) of the people admitted for marijuana were under 20 years old, and many of them started smoking pot at a very early age. Of those admitted for treatment for primary marijuana dependence, 56 percent had first used the drug. 79 by age 14, and 26 percent had begun by age 12.

Sources cited:

—*www.oas.samhsa.gov/2k5/polydrugTX/polydrugTX.cfm*
—*www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts/myth1.pdf*
—*www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts/myth2.pdf*
—*www.whitehousedrugpolicy.gov/publications/marijuana_myths_facts/myth2.pdf*

Daily Marijuana Users and Unemployment

In 2003, an estimated 3.1 million persons age 12 and older used marijuana daily (i.e., on 300 or more days) in the past year according to NSDUH data. Daily marijuana users were more likely to be unemployed when compared with those who had not used it less than daily and those who used it at all in the past year. Nearly two-thirds of daily marijuana users also reported using at least one other illicit drug in the past 12 months.

Source: www.oas.samhsa.gov/2k4/dailyMJ/dailyMJ.cfm.

Date Rape Drugs

by Stephanie Langston

We've all heard about them . . . Roofies, Special K, Liquid X . . . they're part of the reason we've been told to cover our drinks when we go out and why we've been warned to be aware of those around us. Predatory drugs, more commonly known as Date Rape Drugs, have gained notoriety in recent years as substances that can be used to facilitate acts of sexual violence through the incapacitation and exploitation of another person. These drugs are dangerous because of their intended effects. Victims are incapable of making sound decisions, including consenting to intercourse. The problems associated with these drugs are further compounded by their elusive nature. A survivor may not be aware that s/he was drugged, especially in cases where alcohol is involved. These substances affect memory, so survivors may not remember details of the assault, or even that an assault took place. Further, all of these substances are metabolized by the body very quickly. Gamma Hydroxy Butyrate (GHB) for example, is detectable for a mere 12 hours. It may be nearly impossible to verify details of the assault, even if the survivor reports to the authorities within the 72-hour evidence collection window. This can make prosecution extremely difficult.

Three substances have received a huge amount of attention over the past 10 years with regards to sexual assault - Rohypnol, Ketamine and GHB. While fundamentally different in nature, this trio is alike in that all can be mixed into drinks, and all have the possibility of causing anterograde amnesia, a condition in which the events that occurred while under the influence are forgotten. Rohypnol (flunitrazepam) is manufactured in pill form, and is known to be a potent tranquilizer with legitimate roots in treating insomnia. Ingestion of Rohypnol can impair motor function and cause vision problems, in addition to amnesia. Ketamine, legally used as an animal tranquilizer, can be found in both liquid and powder form. Use of Ketamine can lead to hallucinations, dissocitation, and delirium. GHB (gamma hydroxybutyrate) is manufactured in liquid, powder, or pill form. Originally used as a fat burner and sleep aid, the drug was banned by the FDA in 1990. Effects include dizziness, mobility interference and hallucinations.

These illegal drugs are not the only drugs that facilitate date rape. At least one-half of all violent crimes involve alcohol consumption by the perpetrator, the victim or both. Rape is no exception. Alcohol has been the number one facilitator for sexual assault for generations. Of course, alcohol consumption does not invariably lead to assault. But concerns should arise when alcohol is used in excess or in conjunction with other substances because physical effects are often intensified.

In Montana, the primary drug used in the facilitation of sexual assault is alcohol. While it is important to be educated on Ketamine, Rohypnol and GHB, these substances do not appear to be of primary concern across our state. When toxicology screens are performed on sexual assault survivors, the substances most commonly detected are alcohol, over-the-counter medications (such as Benadryl), and prescribed medications (such as Xanax). Investigations are still complicated because it is not always simple to tell whether the survivor willingly took the medication or whether it was mixed into a drink without her/his knowledge. While GHB has played a role in assault, its role has never been as extensive as the role of alcohol.

Education is a big step, but it is not the only step to increasing awareness of sexual assault and working to end violence against women. We are still learning about the drugs used to facilitate sexual assault, and we must be mindful that sexual assault can happen anywhere, at any time, and under any circumstances, regardless of whether alcohol or drugs are involved.

For more information, contact Stephanie Langston at Voices of Hope: vohvista@yahoo.com or (406) 771-8648, ext. 3336.

—Stephanie Langston is a Prevention Resource Center VISTA working with Voices of Hope, a non-profit organization located in Great Falls. This is a volunteer-based organization, staffing both a local crisis line (453-HELP) and a statewide suicide crisis line (1-800-SUICIDE and 1-800-273-TALK).

Statistics on Sexual Assault

— One in four women and one in six men will experience some form of sexual victimization in his or her lifetime (National Institute of Justice, 2000).

— Nearly 7 in 10 rape and sexual assault survivors knew their attackers prior to the assault (Bureau of Justice Statistics, 2000).

— Sexual Violence remains the most dramatically under-reported crime, with an estimated 72% of attacks that go unreported (National Victim Center, 1999).

— 75% of male students and 55% of female students involved in acquaintance rapes had been drinking or using other drugs (National Victim Center, 1999).

— False report of rape is low—the FBI's Uniform Crime Reports suggest that the false report rape is 2-5% or less, the same as for any other felony (FBI, 2000).

For more information on sexual violence or date rape drugs, please visit the Rape, Abuse and Incest National Network at www.rainn.org.

The RADAR Network

The RADAR (Regional Alcohol and Drug Abuse Resource) Network, sponsored by SAMHSA's (Substance Abuse and Mental Health Services Administration) National Clearinghouse for Alcohol and Drug Information (NCADI) is the largest substance abuse prevention and treatment network of its kind. The mission of the RADAR Network is to strengthen communication, prevention and treatment activities among a broad range of organizations to address problems related to substance abuse.

Each state has one RADAR Network State Center serving as a centralized information and distribution service. The responsibility of the state center is to:

1) work with the governing agencies to identify an appropriate State RADAR Network Associate Center;
2) cooperate and communicate with Associate Centers;
3) provide orientation to Associate Centers;
4) order bulk materials from NCADI; and
5) conduct periodic reviews to assess compliance with criteria.

The Addictive and Mental Disorders Division is Montana's State Service Center. Presently, there are 11 Associate RADAR Network sites located in state approved chemical dependency programs. Member selection is based on the following criteria:

1) capacity to provide and/or coordinate prevention outreach to special target populations and/or regions within the state;
2) ability to cooperate with the RADAR Network State Center;
3) ability to participate on or have reasonable access to PREVLINE, the Center for Substance Abuse Prevention's electronic communications system; and
4) commitment to a philosophy consistent with the State plan for substance abuse prevention.

Associate members are responsible for providing a variety of substance abuse materials and topics that are accurate and consistent with current knowledge of sound approaches to prevention, intervention and treatment. They are also responsible for making NCADI materials available/accessible at no profit to the communities they serve; responding to requests for information; and actively marketing substance abuse materials to appropriate target audiences.

Benefits of being an Associate Member include: "care packages" from NCADI that include the latest prevention and treatment materials; the ability to order materials in bulk through the State Member with priority status; free materials that can be used to support community outreach activities; the latest materials from NCADI, including the current TIPS (Treatment Improvement Protocol); the most current prevention campaign information; and updates on a variety of CSAP sponsored events.

For further information about the RADAR Network, check http://ncadi.samhsa.gov/radar activities.aspx or contact Michelle Harbosen at 444-4926 or 1-800-457-2327.

More great PRC resources:

—Visit the PRC webside: www.Prevention.mt.gov

—Subscribe to our weekly Hot News: www.prevention.mt.gov/resource/Hot_News

—Check out the PRC VISTA program: www.prevention.mt.gov/VISTA/AboutUs/AboutVISTA.htm

Lifetime Use: Marijuana and Other Illegal Drugs (2004)			
	Grade 8	Grade 10	Grade 12
Marijuana	18.09%	39.94%	53.58%
Opiates	9.73%	15.81%	18.98%
Hallucinogens	1.81%	5.76%	10.24%
Stimulants	2.52%	5.77%	9.30%
Cocaine	1.72%	3.92%	8.51%
Ecstasy	2.05%	3.71%	5.16%
Sedatives	1.14%	2.59%	4.16%
Number surveyed	6,207	6,688	5,684
Prevention Needs Assessment Data: 2004			

A Dirty (*half*) Dozen

	Phencyclidine (PCP)	Cocaine & Crack	Heroin
Street Names	Angel dust, embalming fluid, killer weed, rocket fuel, supergrass, peace pill, elephant tranquilizers	***Cocaine***: coke, snow, nose candy, flake, blow, white, big C ***Crack***: rock, freebase, baseball, pebbles, 151	Smack, mud, dope, horse, junk, brown sugar, big H, black tar
Type of Drug	Hallucinogen	Stimulant Highly addictive	Opioid Highly add ictive
Appearance	Tablets, capsules and colored powders, from white to tan or brown.	Powder or chips, chunks or rocks	Powder or tar-like substance; white to dark brown
How used	Inhaled, smoked or eaten. Often applied to tobacco or marijuana.	Inhaled, smoked, injected	Inhaled, smoked, or injected
Short-term Effects	– Sweating – Numbness – Loss of coordination – Nausea and vomiting – Blurred vision – Drooling – Illusions or hallucinations – Inability to feel physical pain – Disorientation – Fear, panic – Aggression	– Hallucinations – Dilated pupils – Increased temperature, heart rate & blood pressure – Loss of appetite – Restlessness – Anxiety – Insomnia – Fatigue – Temporary euphoria – Depression – Seizures	– Flushing – Slurred speech – Slow gait – Constricted pupils – Droopy eyelids – Restlessness – Insomnia – Muscle, bone pain – Vomiting – Constipation – Dry skin
Long-term Effects	– Paranoia – Memory loss – Speech difficulties – Weight loss – Loss of fine motor skills and short-term memory – Mood disorders – Depression – Coma – Death	– Paranoia – Aggressive paranoid depression – Ulceration of the mucous membrane of the nose (if snorted) – Heart attack – Respiratory failure – Death	– Collapsed veins – Infection of heart lining and valves – Respiratory depression or failure – Abscesses – Cellulites – Liver disease – Cold flashes with goose bumps – Involuntary kicking movements

	Ecstasy	Methamphetamine	Marijuana
Street Names	MDMA, Adam, Bean, E, M, Roll, X, XTC	Ice, glass, crystal, ice cream, cristy, quartz	Weed, 420, ganja, Mary Jane, sinsemilla, herb, Aunt Mary, skunk, boom, kif, chronic, gangster and at least 200 other names
Type of Drug	Amphetamine-like and hallucinogenic properties	Stimulant Highly addictive	THC (delta-9-tetrahydrocannabinol)
Appearance	Tablets branded with kid-friendly symbols, e.g. cartoon characters, Nike swoosh, CK.	Shards of glass or ice chips.	Green or gray mixture of dried, shredded flowers and leaves
How used	Swallowed in pill form	Inhaled, smoked or injected	Eaten, smoked or brewed into tea
Short-term Effects	– Depression – Sleep problems – Severe anxiety – Paranoia – Confusion – Muscle tension – Involuntary teeth clenching – Blurred vision – Rapid eye movement – Faintness – Nausea – Chills – Sweating	– Irritability – Aggression – Anxiety – Nervousness – Convulsions, – Hallucinations – Insomnia – Increased blood pressure – Loss of appetite	– Problems with memory & learning – Distorted perceptions – Trouble thinking, problem-solving – Loss of coordination – Increase heart rate – Anxiety – Panic attacks – Paranoia – Dry mouth and throat – *Bloodshot eyes*
Long-term Effects	– Long-term damage to parts of brain critical to thought and memory – Long-lasting, permanent damage to neurons that release serotonin	– Extreme paranoia – Toxic psychosis – Hallucinations – Convulsions – Repetitive behaviors – Delusions of parasites or insects under the skin – Stroke – Heart and blood vessel toxicity – Long-term – Damage to brain similar to that caused by stroke or Alzheimer's	– Cancer – Lung – Immune system damage

Source: Partnership for a Drug-Free America, NIDA, DEA *as printed by http://www.drugfreeaz.com/drug/index.html*

Prevention Specialists Contact Sheet

For more information regarding prevention efforts in your community, contact your local Prevention Specialist.

Area	Name	Counties Covered	Address	Phone #	E-mail Address
East	Ronda Welnel	Sheridan, Daniels, Roosevelt, Richland,Dawson, McCone, Valley, Philips, Garfield, Wibaux, Prairie, , Custer, Rosebud, Treasure, Powder River, Fallon, Carter	209 2nd St. SE Sidney, MT 59270	406-433-4097	rwelnel@hotmail.com
	Laura Harper	Big Horn, Musselshell, Fergus, Petroleum, Golden Valley, Judith Basin, Wheatland, Stillwater, Yellowstone, Carbon, Sweetgrass	201 N. 25th St. Billings, MT 59101	406-254-1314	harperlm1976@yahoo.com
Central	Collette Stinar	Cascade	2211 5th Ave. N. Great Falls, MT 59401	406-452-6655	collette@gatewayrecovery.org
	Becky Robideaux	Gallatin	502 So. 19th Ave. Suite 302 Bozeman, MT 59718	406-586-5943	beckyr@cu.imt.net
	Charles Walker	Broadwater, Jefferson, Lewis and Clark	P.O. Box 1153 Helena, MT 59624	406-443-2343	cwalker@boydandrew.com
	Linda Budeski	Meager, Park	430 E. Park Livingston MT 59047	406-222-2812	onehorseplace@aol.com
	Carol Richards	Glacier, Toole, Liberty, Hill, Blaine, Pondera, Teton, Choteau	21 1st St NW, Office #1 Choteau, MT 59422	406-622-3211	tlccarol@ttc-cmc.net
West	Linda Budeski	Madison, Beaverhead	430 E. Park Livingston, MT 59047	406-222-2812	onehorseplace@aol.com
	Dan Haffey	Silverbow	125 W. Granite Suite 101 Butte, MT 59701	406-497-5070	dhaffey@co.silverbow.mt.us
	Rosie Buzzas	Mineral, Missoula, Ravalli, northern portion of Granite, Powell	1325 Wyoming Missoula, MT 59802	406-532-9800	rbuzzas@wmmhc.org
	Barney Stucker	Lincoln, Sanders, Flathead	P.O. Box 7115 Kalispell, MT 59904	406-756-6453	barneyfvcdc1@centurytel.net
	Ralph Stever	Lincoln	P.O. Box 756 Libby, MT 59923	406-296-2822	musicalgraffiti@yahoo.com
	Beulla Kingston	Lake	802 Main St. Ste C Polson, MT 59860	406-883-7310	lccdp@compuplus.net
	Loren Johnston	Deer Lodge, southern portion of Granite	118 E 7th Ste 2E P.O. Box 758 Anaconda, MT 59711	406-563-6601	native@in-tch.com
Reservations					
	Jackie Jandt	Blackfeet, Flathead, Rocky Boys, Fort Belknap, Fort Peck, Northern Cheyenne, Crow	P.O. Box 202905 555 Fuller Helena, MT 59620	406-444-9656	jjandt@state.mt.us

Addressing Meth: *Notes from the Attorney General's Office*

by Lynn Solomon

It sounds like a broken record, but in Montana, any discussion of illegal drugs starts with a discussion of methamphetamine. Meth is not the only illegal drug in Montana. It is, however, the drug that consumes the time, talent and resources of hundreds of Montana professionals involved in law enforcement, corrections, victim services, child protection, treatment, investigation and the forensic sciences. Nearly every day, the Montana Department of Justice and the office of Attorney General Mike McGrath contend with issues and questions related to methamphetamine. Here's a look at some of our most recent projects.

Western Attorneys General

In late February, Attorney General McGrath and nine other attorneys general took part in a one-day methamphetamine summit in Scottsdale, Ariz.

The attorneys general agreed on a number of strategies to address meth use and production.

— Pursue a comprehensive, aggressive approach that addresses prevention through education, vigorous law enforcement and treatment of meth addiction.

— Make pills containing pseudoephedrine, the drug essential to producing meth, harder to get by placing them behind pharmacy counters and requiring buyers to show identification and sign a log to get them.

— Do everything possible to protect children, who are often innocent victims of meth use and production.

— Step up efforts to intercept meth precursors coming from Mexico and combat meth production from so-called "super labs."

— Work with federal partners to secure continued financial support for law enforcement.

— Mount a broad-based prevention and education campaign to inform both adults and young people of the dangers of meth use.

Prevention and Education

The Winter 2004 *Prevention Connection* had a piece on a "Tools for Schools" project. The project is a collaboration between the DOJ, the Office of Public Instruction and the Montana 4-H Center for Youth Development. The project includes PowerPoint presentations, curriculum guides, games and other activities for teachers. It will be finished this summer and, hopefully, available to teachers in time for teacher in-service training and teachers' statewide conferences in the fall.

Along the same lines, the Department of Justice and the MSU Extension Service have also collaborated on a "toolkit." It includes a variety of pieces, which fit in a flip-top box. Kits include:

— "Filler" ads for newspapers and newsletters. These ads have a simple anti-meth message, and they are standard sizes. Editors and publishers can use them to fill out a page layout.

— Video public service announcements. The PSAs feature Bozeman police officer Bryan Adams and Mary Haydal. Mrs. Haydal's daughter died as a result of meth use.

— A general information brochure with basic information about meth, along with links and contact information. Additional inserts include information for specific audiences, including retailers, people who handle agricultural chemicals, landlords, motel workers or anyone who may come across lab waste outdoors.

— Bookmarks and a poster with basic information and links.

These more recent projects complement the Department of Justice's ongoing work related to meth. In the past year, there has a been training on drug-endangered children, rural outreach to Montanans who may be working with agricultural chemicals (especially anhydrous ammonia), and the Bridge Program, a partnership between DOJ and the Department of Public Health and Human Services. The program helps fund three residential recovery homes for drug-addicted women and their children.

The department supported a number of meth-related bills during the 2005 Legislature, including bills to regulate the sale of the meth precursor pseudoephedrine and maintain funding for Montana's drug task forces.

Day-by-Day

Meth is not the only illegal drug in Montana, but nearly every day, the Department of Justice is addressing its production, sale and use and the challenges and problems that accompany it. So too are families, communities and schools across the state. While methamphetamine dominates any discussion of illegal drugs in Montana, it is also drawing communities together in efforts to combat it.

Much has been done. Awareness is increasing, and the Montana Department of Justice is committed to continuing to support a broad range of prevention, education and enforcement strategies.

For more information, contact the Department of Justice at (406) 444-2026 or visit www.doj.state.mt.us

Wilderness Treatment Center

by John Brekke

Prevention is a big word for all of us who work in primary in-patient treatment for chemical dependency. Historically, the treatment process has been well defined—28 days . . . l2 Steps . . . complete the first five steps in the facility and go to aftercare. Unfortunately, this adult model did not seem to be successful with adolescents. They would leave treatment feeling motivated and willing to stay in recovery, but their relapse rate was much higher than that of adults.

Preventing relapse in adolescents became a high priority when Wilderness Treatment Center started in l983. We believed that the primary difference between adults and adolescents who were new to recovery came down to self-esteem. Most adults—once recovered—had past successes to fall back on. They'd been good mothers or fathers, husbands or wives . . . had successfully held jobs and had many other successes in life. Once in recovery, the adult could look back and recognize that the addiction was what took their successes away. This foundation, combined with quality treatment, was a formula for ongoing recovery. But what could adolescents look back on? Most adolescents in recovery are in trouble at school, home, and in their social lives. Many, if not most, were also in trouble with the law. Between their age and their addictions, young people had not had time to rack up many successes. Ultimately, we asked ourselves whether we would leave the self esteem issue up to the aftercare phase – or whether we'd deal with it in primary treatment.

Outward Bound gained prominence in the late '70s and early '80s for its work in helping people in all age groups develop self esteem. The program they developed for inner city delinquents in l968 proved very effective in helping youth develop a realistic sense of self esteem.

At Wilderness Treatment Center (WTC), we decided to deal with the self esteem issue while the adolescent/young adult was in primary treatment. On a practical note, we had to ask whether parents and insurance companies would accept the 60-day treatment period, which was nearly twice as long as the standard 28 day period. This mean coming up with independent outcome studies that demonstrated that the model works.

WTC combined two proven programs: the Minnesota Model of Treatment and Outward Bound. Each patient stays for 60 days. The first 30 days are similar to all quality treatment centers. Patients are in therapy from 9:00 a.m. to 8:00 p.m. every day, participating in a combination of group, lectures and individual therapy as well as Alcoholics and or Narcotics Anonymous meetings. During the second 30 days, they complete a l6-2l day wilderness trip. A licensed Addictions Counselor is in attendance on all expeditions. For l6 years, A & A Research—an independent firm in Kalispell—followed WTC patients for two years after participation in the program. At two years, 60 percent remained drug and alcohol free and nearly all (75.8 percent) stated the wilderness expedition had been the most valuable experience in their recovery.

We believe the primary tool for preventing relapse in adolescent/young adults is developing a realistic self esteem with ongoing commitment to recovery. Just knowing how to stay sober is not enough . . . the other key component to continued sobriety is feeling capable of *staying* sober.

—Wilderness Treatment Center (WTC) is a licensed, free-standing, in-patient treatment center that utilizes the steps of A.A. and N.A. The program is medically supervised. WTC is a 60-day, in-patient center for males between the ages of 14-24. For more information, call 406-854-4832.

A Miracle Long Overdue: *Buprenorphine*

by Dr. Dan Nauts

History tells us that on the other side of stimulant epidemics (e.g. methamphetamine) lurks an opioid epidemic. It is already here.

—Opioids include a variety of sedative narcotics containing opium or one or more of its natural or synthetic derivatives. They have sedative or narcotic effects, dull the senses, induce euphoria, relaxation or torpor.

For several years, addictionists nationwide anticipated Federal Drug Administration (FDA) approval of *buprenorphine*. This medication can be used to stabilize patients addicted to opioids, and to reduce the effects of withdrawal. When buprenorphine was approved in October 2002, it was heralded as the first time addictionists and other appropriately trained physicians could detoxify and/or maintain patients/clients who had a primary diagnosis of opioid dependence.

The goals of buprenorphine treatment are simple:

1. Provide humane, compassionate and effective withdrawal management.
2. Facilitate entry into treatment and subsequent harm reduction.
3. Diminish urges and cravings preventing lapse and relapse – both with pharmacology and treatment engagement.
4. Prevent medical complications e.g. HIV, Hepatitus B and C and endocarditis.
5. Diminish economic and legal consequences of illicit use.

My experience with these new tools has been gratifying, if not frankly miraculous. Stability of function manifested by employment, family reconciliation, diminished legal issues, and the return of emotional and physical health are all possible.

How does it work?

Buprenorphine is an "opioid partial agonist" and "partial antagonist."

It can produce typical opioid agonist side effects, such as euphoria and respiratory depression, though less than the effects of oxycodone or heroin. At low doses, buprenorphine allows chronically opioid dependent individuals to feel "normal" without cravings. It provides the stability necessary to allow patients to gain from psychosocial treatment.

The agonist affects of buprenorphine increase linearly with increasing doses until at moderate dose a plateau is reached. At higher doses, the antagonist effects can manifest with possible withdrawal. Furthermore, if buprenorphine is given to an opioid dependent individual with a full agonist (e.g. oxycodone) in the bloodstream, withdrawal may be precipitated. There are built-in safeguards.

Licensing

Though the complex licensing to provide methadone or LAAM (an oral narcotic analgesic used to treat opiate dependencies) was not necessary to prescribe buprenorphine, either addiction subspecialty certification or participation in an 8-hour buprenorphine training course was required to receive the buprenorphine waiver to the doctor's controlled substance registration.

Currently six Montana physicians are listed on the SAMHSA/CSAT Web site, as having the waiver. Unfortunately, the Drug Addiction Treatment Act of 2000, limits physicians or physician groups practices to prescribing buprenorphine for opioid addiction to a maximum of 30 patients at one time.

Sadly, physicians actively involved in addictions treatment are either full or nearly full. Ironically, physicians can prescribe other opioids such as Oxycontin to unlimited patients. Buprenorphine is not perfect, but it allows us to address the needs of a population of dependent persons with whom we were woefully inadequate in the past. Individuals actively using other substances in particular methamphetamines have a poor prognosis with buprenorphine treatment.

History tells us that on the other side of stimulant epidemics (e.g. methamphetamine) lurks an opioid epidemic. It is already here. More doctors need to get waivers and learn how to collaborate with addictions treatment programs. The 30 patient limit needs to go away and more than one doctor per clinic needs to be allowed. Congress is considering changes at this time.

—Daniel A. Nauts is an M.D. and an Addictionist. He works for Benefis Healthcare Behavioral Health Services as well as for Western Montana Addiction Services.

Opioids induce euphoric effects and are reported to reduce anxiety and temporarily increase self esteem. Opioids can produce a pleasurable, dreamy, oceanic feeling, though when people are first exposed, they may be nauseous. Physical signs of opioid abuse include small pupils, decreased breathing and constipation.

Opioids fall into two major categories. Some are derived from naturally occurring substances, such as morphine and codeine, while others are synthetically produced, such as Oxycontin or Vicodin. Rapid development of physical dependence and a protracted abstinence syndrome are unique to opioid use and can make abstinence difficult.

Following national trends, OxyContin has become a pharmaceutical drug of abuse in Montana, with quantities illegally distributed in various areas in the state. Dilaudid and other opiate pain killers are also in demand on the illicit market.

Truancy Intervention Program (T.I.P.)

by Sarah Volesky

PNA Data Bite: Opiates

The 2004 Prevention Needs Assessment revealed that 18.98 percent of Montana 12th graders had tried opiates at some point in their lives; 8.18 percent had used them within the past 30 days.

PNA Data Bite: Stimulants

2004 Prevention Needs Assessment data revealed that 9.3 percent of Montana 12th graders had tried stimulants at some point during their lives, and that 3.1 percent had used them within the past 30 days. 8.51 percent had used cocaine at some point during their lives, and 2.28 percent had used it within the past 30 days.

Nationally, researchers have demonstrated that truancy is a risk factor for delinquent behavior in youth and can be correlated with substance abuse, teen pregnancy, school drop out and involvement in criminal activities such as burglary, theft and vandalism. According to the Office of Juvenile Justice and Delinquency Prevention, academic failure is often associated with the beginning of delinquency and the escalation of serious offending. Interventions that improve a child's academic performance have been shown to reduce delinquency. A growing body of research also demonstrates that as early as first grade, children who miss more than 14 days of school during the semester are at substantially higher risk of dropping out of school than children with more consistent attendance.

Locally, school district officials have reported a persistent problem with young adolescents and children who are either truant or who accumulate excessive excused absences. Referrals to the 1st Judicial District Youth Court involving habitual status and delinquent offenders generally involve failure in school that can be associated with a history of truancy, often dating back to early childhood.

Lewis and Clark County and the 1st Judicial District Juvenile Probation Office recently collaborated on a program designed to more effectively respond to Helena's growing truancy problem, in particular to chronic truancy and school absence. The program goal was to prevent high-risk youth from ultimately dropping out of school by identifying them early in their educational careers and providing them—and their families—with supportive services. This program was designed to reduce the incidence of truancy and unnecessary absences, as well as reduce the risk of future delinquent behavior.

Currently 3,838 elementary students, 2061 middle school students and 2,746 high school students are enrolled in Helena School District #1 and East Helena School District #9. School resource officers, juvenile probation officers, school district personnel and youth-service agencies are involved on a daily basis in developing youth assets and in responding to the aftermath of poor choices. While these agencies can respond to many identified youth, school administrators have reported an increase in the number of chronically absent students who are not served in this community. Typically these students come from families for whom education is not a high priority. They are often unmotivated. Because many fall into the economic category of working poor, they often exist under the radar of programs or do not qualify for services available to youth and families in poverty. Often these students are reported as truant or as having excessive excused absences. Some parents may falsely report that the child is being home schooled in order to avoid disciplinary action from the district and/or the county attorney's office.

The Truancy Intervention Program (T.I.P.) offers a means to intervene and to work with these families in order to prevent dire legal and academic ramifications. By working closely with community schools, agencies and programs, T.I.P. provides an opportunity to intervene early and to help ensure accountability and school attendance. Staff gathers demographic data to describe current truants and their families in an effort to identify—and serve—other at-risk youth.

When this program was initially developed, the target age group was third through eighth grades, but we have also begun working with some first graders. In speaking with school administrators, we have learned that there are also students in kindergarten who could benefit. We currently serve eight families and have a capacity to serve thirteen. So far, the youth we are working with have been regularly attending school and are demonstrating significant academic progress. We are now planning our summer program. Our goal is to get these students up to grade level, as well as to promote prosocial involvement by including them in fun activities in the community. Our hope is that this progress will continue to grow.

—Sarah Volesky is a Truancy Intervention Specialist for Montana Youth Homes in Helena.

Youth Connection: *Prevention in Helena's Public Schools*

by Casey Molloy

In step with the evolution of prevention, the Helena Public Schools recognized that the most effective way to address high-risk behaviors within the school system was through collaborative efforts that included the community. In Spring 2003, the Helena School District successfully applied for a *Community Support Grant* through the Department of Justice. The district used the funding to recruit community members who ultimately came together as the coalition *Youth Connections*.

The coalition operates under the *40 Developmental Asset Framework* created by Minnesota-based Search Institute. This framework looks at 40 research-based "building blocks" that every child needs to grow up healthy. The more assets children have in their lives, the better protected they are from engaging in high-risk behaviors and the more likely they are to succeed academically.

Youth Connections has adopted a three-pronged approach to asset development:

1) Training staff and teachers in the asset model so that it can be incorporated in the school environment;
2) Training students in the asset model to teach them how to create a more positive and caring school environment where students feel safe; and
3) Training community members in the asset development model so it can be used with youth in all facets of their lives from extra-curricular activities to the home.

Most schools in the Helena School District have a team that deals with teaching appropriate behaviors and offering opportunities to practice these behaviors, as outlined by the Montana Behavior Initiative from the State of Montana Office of Public Instruction. These school-based MBI programs address many of the assets, including: creating a caring school climate; empowering youth with leadership roles; establishing boundaries; providing opportunities for service; creating other adult relationships; providing for parent involvement in schools; making students feel safe while at school; providing positive adult role models; encouraging positive peer influence; encouraging high expectations; offering opportunities for creative activities; and offering opportunities for involvement in extracurricular activities.

The asset model is increasingly incorporated in the school atmosphere. Both middle schools in Helena have created *greeter* programs. Parents and community members come into the school mornings and greet students as they enter the building. This helps create a caring environment where students feel recognized by other adults in the community. The middle and high schools have also adopted transition programs. At the middle school level, the WEB Program (Welcome Every Body) allows 6th graders to spend the first day of school with upperclassmen and teachers who introduce the concepts of the middle school environment. Likewise, 9th graders spend their first day of school as a group with a transition team of upperclassmen and teachers. This transition day is designed to give incoming students a chance to become acquainted with the building and other students in a supervised setting, and to participate in many team-building activities.

Youth Connections also interfaces with other prevention efforts. The Montana National Guard Drug Demand Reduction Program has become an integral part of our prevention efforts. Through development of their drug prevention curriculum, National Guard members are the lead instructors for the drug prevention curriculums in both middle schools in the district.

Girl Power is a national Department of Public Health and Human Services Program that has been taught to 6th and 7th grade girls at CR Anderson Middle School for the past three years. In partnership with Boyd Andrew Community Services, this volunteer program is offered during lunch once a week for 12 weeks. Interested girls learn about topics that include body image, eating disorders, drug and alcohol issues, self-esteem, peer pressure, and communication.

In the past, *Insight* classes have been offered at Helena and Capital high schools. Originally designed as a prescreening and educational group for students with alcohol or drug violations, *Insight* has evolved into a program now offered at the middle schools as well. Trained teams at both levels offer the 10-hour class to students and their parents.

All of these programs have been incorporated into a comprehensive program to reduce risks and increase assets among our students. Research proves this approach results in improved academic achievement, as students feel safer and more supported in their school community. The Helena School District, working through *Youth Connections*, is committed to growing and continuing to develop these important efforts.

For more information, contact Casey Molloy, Safe & Drug Free Schools Coordinator, at cmolloy@helena.k12.mt.us.

Youth Connections has more than 75 members representing 45 sectors of the community. To date, more than 1,100 community members, 400 school personnel and 1,000 students have been trained in the asset model.

Helena Public Schools

The Negative Effects of Marijuana

Marijuana is addictive

— Research has now established that marijuana is addictive. In fact, more youth enter treatment with a primary diagnosis for marijuana dependency each year than for all other illicit drugs combined.

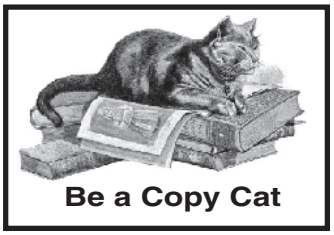
— 60% of teens currently in drug treatment have a primary marijuana diagnosis.

— Today's marijuana is more potent and its effects can be more intense.

Marijuana hurts young bodies and minds

— *The brain.* Smoking marijuana leads to changes in the brain similar to those caused by cocaine, heroin and alcohol.

— *Lung damage.* Regular marijuana users often develop breathing problems, including chronic coughing and wheezing. Smoking marijuana makes lung conditions such as asthma worse.



Be a Copy Cat

— *Mental health.* For young users, marijuana can lead to increased anxiety, panic attacks, depression and other mental health problems.

— *Risky behavior.* According to the 2001 National Household Survey on Drug Abuse, adolescents age 12 to 17 who use marijuana weekly are nine times more likely than non-users to experiment with other illegal drugs or alcohol, five times more likely to steal and nearly four times more likely to engage in violence.

Marijuana affects learning and academic achievement and impairs driving

— Researchers have found that heavy marijuana use impairs the ability of young people to concentrate and retain information.

— Marijuana affects alertness, concentration, perception, coordination and reaction time, many of the skills required for driving and other tasks. These effects can last up to four hours after smoking marijuana.

Marijuana today is stronger than ever

— Marijuana is much stronger and more addictive than it was 30 years ago. The average THC level rose from less than 1% in the late 1970s to more than 7% in 2001.

— Sinsemilla potency has increased, rising from 6% to 13%. THC levels of 20% and up to 33% have been found in samples of sinsemilla.

Marijuana users are younger than ever

— Every day in 1999, more than 3,800 youth ages 12-17 tried marijuana for the first time. That's more than tobacco.

— The number of eighth graders who have used marijuana doubled between 1991 and 2001, from one in 10 to one in five.

— Scientists now know that humans undergo a second major spurt of brain development in their early teens: Marijuana use at this age could pose great risks for the health and development of young people.

— Research reported by NIDA shows marijuana's effects on the brain can cause cumulative deterioration of critical life skills.

— Young marijuana users often introduce other youth to the drug, according to a January 2003 report in the *Journal of the American Medical Association.*

Parents Make a Difference

Parents are the most powerful influence on their children when it comes to drugs.

— 2/3 of youth ages 13-17 say losing their parents' respect is one of the main reasons they don't smoke marijuana or use other drugs.

— In 2000, 31% of youth whose parents did not strongly disapprove reported use of an illicit drug in the past month.

— Parents who perceive little risk associated with marijuana use have children with similar beliefs.

Continued on Page 21

Heroin—Changes in Use

Data on substance abuse treatment admissions from TEDS show that between 1992 and 2002, inhalation increased as the route of administration from 20 to 33 percent of primary heroin admissions, while injection decreased from 77 to 62 percent.

www.oas.samhsa.gov/2k4/HeroinTrends/HeroinTrends.cfm

Marijuana is not a rite of passage but a dangerous behavior that could have serious health consequences. Parents must realize that what they tell their children about drug use makes a difference.

—Richard Carmona, M.D., U.S. Surgeon General

Negative Effects of Marijuana

Continued from Page 20

Research shows that many parents:

— Are ambivalent about marijuana, considering it to be relatively risk-free;

— Neglect to refer to marijuana use when talking to their children about drugs;

— Are more concerned about so-called "hard" drugs and the dramatic increase in use of Ecstasy and other club drugs;

— Do not fully appreciate the specific dangers of marijuana today—drawing on, in some cases, their own experiences with the drug;

— Do not realize how young children are when they start to smoke marijuana.

Parents need to understand that marijuana is not an "outdated" drug—it is by far the most widely used illicit drug among youth today;

— Marijuana is not relatively "risk-free"—it is a harmful, addictive drug that can increase risk taking behaviors that can jeopardize a young person's future (e.g., pregnancy, car crashes, losing a job or scholarship, and criminal behavior);

— While people of their generation may have "experimented with pot," the increased potency of marijuana today means far greater risks for their own children, who typically are trying it at much younger ages;

— Marijuana is often adulterated with other substances (e.g., sometimes a marijuana joint is dipped in embalming fluid, then PCP is added), increasing the risks and hazards;

— They are the key to fostering a serious attitude about marijuana in young people. The best thing parents can do is talk to their children about drugs, including marijuana, and carefully monitor their activities.

Addressing false beliefs

Since the 1990s, marijuana use among youth has increased as perceptions of risk and peer disapproval have declined. Young people's attitude is often: "If marijuana was bad for me I would have heard about it." The trouble is a lot of stories, myths and false anecdotal information about marijuana circulate unchallenged.

The message

— Provide factual information about the drug. It is important to be honest and not to exaggerate or create more myths.

— Discuss "short-term" effects, such as losing control and doing something stupid or that the teen may regret, which young people relate to better than long-term, future consequences, such as lung cancer.

— Provide evidence that marijuana is addictive. Make it clear that marijuana can end up controlling the user—not the other way around.

Medical Marijuana

Young people often interpret the pro-marijuana messages of medicinal use and legalization campaigns in the media as meaning that marijuana is harmless or even beneficial in some way. Disturbingly, interviews with teens found that some believe that marijuana can cure cancer and other serious diseases. Prevention efforts must be sure to dispel these sorts of myths. Note that:

— Research has NOT demonstrated that smoked marijuana can be helpful as medicine; Marinol, a prescription drug approved by the FDA, is a medicine—smoked marijuana is not;

— Smoked marijuana contains more than 400 chemicals and increases risk of cancer, lung damage and pregnancy complications.

— Coalitions should know that some drug legalizers may use "medical marijuana" as a red herring in an effort to advocate broader legalization of drug use.

Source: Strategizer 44: *Marijuana–Debunking the Myths.* Community Anti-Drug Coalitions of America. *www.mediacampaign. org/marijuana/Strategizer.pdf*

DAYMINDER

Teens and Drugs Today

10th Annual Rocky Mountain Mental Health Symposium

September 15, 16, and 17, 2005

Grouse Mountain Lodge, Whitefish

This conference is intended for all professionals who seek to broaden their understanding of the addiction issues facing teens, as well as the treatment applications facilitating recovery.

Topics will include:

1. *biology of addiction;*
2. *dual diagnosis;*
3. *prevention; and*
4. *recent trends and treatment.*

A schedule of presentations will be available in early summer 2005.

Sponsored by:
Pathways Treatment Center/Kalispell Regional Medical Center, in collaboration with
Montana Health & Human Services: Addictive and Mental Disorders Division.

For reservations, contact 866.755.4658.

Laws and Legislation: *Update 2005*

Montana's 2005 Legislative Session brought with it a total of 68 Bills that had something to do with alcohol and/or drugs; 42 of them were ultimately introduced in either the House or Senate. When it was all said and done, 21 passed. Following is a summary of some that passed and a few that didn't.

House Bill 31: Establish an Office of Substance Abuse Prevention and Treatment and a Commissioner to preside over that office, as a replacement for the Interagency Coordinating Council for State Prevention Programs.

Status: Missed deadline for appropriation bill transmittal. Dead.

House Bill 73: An act authorizing a county, city, town, or municipality to impose a voter-approved levy for programs that prevent substance abuse.

Status: Passed into law 4/8/2005. Signed by Governor Schweitzer 4/21/2005. This act is effective July 1, 2005.

House Bill 99: Increases the penalty for driving when license is suspended or revoked for DUI or for test refusal. The penalty for driving when license is suspended or revoked is seizure of the vehicle or rendering the vehicle inoperable, in addition to terms of imprisonment and fines that escalate with second and subsequent offenses.

Status: Passed. Transmitted to Governor 4/27/2005.

House Bill 252: This act would increase taxes on alcoholic beverages, with the revenue to be used by the Department of Public Health and Human Services for the prevention or treatment of effects related to fetal alcohol syndrome.

Status: Missed deadline for revenue bill transmittal. Dead.

House Bill 358: An act providing for certification of problem gambling counselors by the Department of Labor and Industry. This act also provided means for the Department of Public Health and Human Services to develop a pathological gambling and problem gambling prevention program as well as a statewide plan.

Status: Missed deadline for General Bill transmittal. Dead.

House Bill 255: Redefine mental disorder to include co-occurring chemical dependency or addiction.

Status: Passed and signed by Governor Schweitzer 3/24/2005.

House Bill 348: An act restricting youth access to alcohol and providing for registration and record-keeping on sales of kegs of beer. This bill would also initiate fines for violation.

Status: Passed. Currently enrolling and in final preparation process.

House Bill 349: This act revised statutes concerning public intoxication and the treatment of alcoholism, eliminating the requirement that police take persons incapacitated by alcohol into protective custody. Public intoxication is not a criminal offense—a person who appears to be intoxicated in public does not commit a criminal offense solely by reason of being intoxicated, but may be detained by a peace officer for the person's own protection.

Status: Passed. Transmitted to Governor for signature 4/18/2005.

House Bill 374: This act increased the incarceration time and fine that may be imposed for first through third convictions of driving while under the influence or with an excessive alcohol concentration if one or more passengers under 16 years of age were in the vehicle at the time of the offense.

Status: Passed. Transmitted to Governor 4/19/2005.

House Bill 721: The Montana Drug Offender Accountability and Treatment Act allows each judicial district or court of limited jurisdiction to establish a drug treatment court. These courts may process drug offenders in order to address identified substance abuse problems as a condition of pretrial release, pretrial diversion, probation, incarceration, parole or other release from a detention or correctional facility. Participation is voluntary and subject to the consent of the prosecutor, defense attorney, and court pursuant to a written agreement.

Status: Signed by Governor Schweitzer. A Chapter Number was assigned 4/19/2005.

Continued on Page 23

Laws

For more information on the 2005 Regular Legislative Session, legislation considered and passed, status and text of bills, votes, legislator requests and more, visit the 2005 Session LAWS database at http://leg.state.mt.us/css/sessions/59th/

As established by the 1972 Montana Constitution, the Legislature consists of a Senate and a House of Representatives. Sessions take place every odd-numbered year and last for a maximum of 90 legislative days. Requests for bills can only be made by elected legislators, so if you're interested in bringing about a change in the law, the first step is to identify representatives or legislators who may be interested in proposing a change. Visit http://leg.state.mt.us/css/about for more information.

Laws and Legislation: 2005

Continued from Page 22

House Joint Resolution 1: This Joint Resolution of the Senate and the House of Representatives urges the Governor, the Department of Public Health and Human Services and the Department of Corrections to continue efforts toward intra-agency and interagency prevention coordination and to support interagency efforts to combat the substantial effects of substance abuse, especially methamphetamine use, on our society.

Status: Passed. Filed with the Secretary of State 4/18/2005.

Senate Bill 80: This act prohibits open alcohol containers in vehicles.

A person commits the offense of unlawful possession of an open alcoholic beverage container in a motor vehicle if the person knowingly possesses an open alcoholic beverage container within the passenger area of a motor vehicle on a highway.

Status: Passed. Signed by Governor Schweitzer 4/21/05; Chapter Number assigned 4/22/05.

Senate Bill 166: This ace revises methamphetamine enforcement laws, making theft of any amount of anhydrous ammonia for the purpose of manufacturing dangerous drugs a felony. Additionally, this criminalizes possession of a number of other precursors to the manufacture of methamphetamine. A person convicted of criminal possession of precursors to dangerous drugs faces imprisonment and/or substantial fines.

Status: Passed. Signed by Governor Schweitzer 3/30/2005.

Senate Bill 249: This act provided for a statewide continuum of care in the areas of prevention, intervention and treatment for chemical dependency and co-occurring disorders in programs administered by the Department of Public Health and Human Services and the Department of Corrections.

Status: Dead.

Senate Bill 287: This act regulates ephedrine and pseudoephedrine by providing that products containing either ingredient must be sold in a licensed pharmacy or retail establishment under restricted conditions and in limited quantities. This act provides for a voluntary retail Methamphetamine Watch Program and requires the Department of Justice to provide grants to assist public and private organizations in activities supporting that program. This act also provides immunity for a person reporting under the Methamphetamine Watch Program.

Status: Passed and in final preparation process.

Senate Bill 343: This act would have attached a tax to each barrel (31 gallons) of beer sold in Montana.

Status: Missed deadline for revenue bill transmittal. Dead.

Senate Bill 387: This act provided for alternative sentencing to a residential methamphetamine treatment program for persons convicted of a second or subsequent offense of possession of methamphetamine. It also provided conditions for placement and aftercare and required the Department of Corrections to issue a request for proposals for any contract to operate a residential methamphetamine treatment program

Status: Missed deadline for General Bill transmittal. Dead.

Senate Bill 407: This act revised the minor in possession law. In each case, the parent(s) or guardian(s) will be ordered to complete and pay all costs of participation in a community-based substance abuse information course. If the convicted person fails to complete the community-based substance abuse course and has a driver's license, the court shall order the license suspended for 3 months for a first offense, 9 months for a second offense, and 12 months for a third or subsequent offense.

Status: Passed. Transmitted to Governor Schweitzer 4/21/2005.

Good Resources

National Institute on Drug Abuse: Marijuana
www.drugabuse.gov/drugpages/marijuana.html

Parenting of Adolescents
www.parentingteens.about.com/

Parents: the Anti-Drug
http://theantidrug.com/

The Office of National Drug Control Policy
http://whitehousedrugpolicy.gov/

Drug Free Arizona: Types of Drugs
www.drugfreeaz.com/drug

Montana Prevention Resource Center
http://Prevention.mt.gov

Montana Department of Justice Attorney General's Office
Meth in Montana
www.doj.state.mt.us/safety/methinmontana.asp

JoinTogether.org
to advance effective alcohol and drug control policy, prevention and treatment
http://www.jointogether.org/home/

The Last Word

by Joan Cassidy, Bureau Chief

—Evidence-based prevention is a crucial tool, and we're getting better at it all the time. Treatment is another critical tool, and we're getting better at that, too.

There has been a lot of media focus on methamphetamine, during and before the last legislative session. Use is on the rise because it's accessible and relatively inexpensive . . . at least to start with. There is no question that meth is a huge problem for many of Montana's communities, but we must not lose sight of the fact that this is not our only substance abuse problem. The use of many other drugs, including marijuana, can be as devastating as methamphetamine even though the effects may not be as apparent as quickly.

Substance abuse overall—rather than abuse of a single substance—is rampant in Montana. It impacts individuals, families, communities and our state. For this reason, rather than focusing on a single drug, we must take a step back and look at the big picture. The impacts of *addiction* on communities, families and health are excruciating, whether we're talking about marijuana, alcohol, meth, prescription drugs . . . or any one of a host of other substances.

The other danger of focusing on a single drug is that few drug abusers just use a single drug. Most use multiple substances, despite having a "drug of choice." In the real world, drug use is more often than not polydrug abuse, and often *drug of choice* could be more accurately stated as *drug of opportunity.* Use generally comes down to availability and accessibility.

Prevention Needs Assessment data for 2004 tells us that 32 percent of 12th graders used some drug within the past 30 days, and 60.21 percent have used some drug during their lives. The big picture becomes even clearer when we see the growing waiting lists for the Montana Chemical Dependency Center and realize that alcohol, marijuana and methamphetamine consistently come in as the top three substances people are in treatment for in the publicly funded system.

We've focused a lot on marijuana in this issue—in November, we'll focus on alcohol and other legal drugs. All are important. The kid with a drug problem didn't start out using meth . . . or even marijuana. Statistically, that kid probably started by trying tobacco and alcohol. Early use of any drug—legal or illegal—makes continued and escalating use more likely. It doesn't help that in deed and in word, we often convey an attitude that substance abuse is acceptable, that we condone—at least *some*—use, whether that's beer or chewing tobacco . . . or marijuana.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

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